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LONG-TERM CARE SERVICES FOR THE ELDERLY

Background Materials on Financing and Delivery of Long-Term Care Services for the Elderly

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A REPORT

PREPARED BY THE

CONGRESSIONAL RESEARCH SERVICE

FOR THE USE OF THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON ENERGY AND COMMERCE

U.S. HOUSE OF REPRESENTATIVES

JULY 1986

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LETTER OF SUBMITTAL

June 17, 1986

Honorable Henry A. Waxman
Chairman, Subcommittee on Health
and the Environment
Committee on Energy and Commerce
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

In response to your request, I am pleased to submit to you a comprehensive report on financing and delivery of long-term care services for the elderly.

The report describes various social and economic characteristics of the elderly and their need for long-term care services, and discusses the major Federal programs supporting long-term care as well as private sector approaches to financing and delivery of long-term care services.

Jeanne Griffith, Specialist in Social Legislation of the Education and Public Welfare Division, wrote the section on the social and economic characteristics of the elderly population, and Richard Price and Carol O'Shaughnessy, also of the Education and Public Welfare Division, wrote the sections on utilization of services, and public sector programs and private sector approaches for the financing and delivery of long-term care services.

We hope that this report will serve the needs of your committee as well as those of other committees and Members of Congress concerned with long-term care services for the elderly.

Sincerely,

Joseph E. Ross
Director

Enclosure

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LETTER OF TRANSMITTAL

House of Representatives
Subcommittee on Health
and the Environment
Washington, D.C. 20515
June 1986

Honorable John D. Dingell
Chairman, Committee on Energy and Commerce
Washington, D.C. 20515

Dear Mr. Chairman:

The attached report prepared by the Congressional Research Service, at the request of the Subcommittee on Health and the Environment, contains background information on the financing and delivery of long-term care services for the Nation's elderly. The report provides an overview of selected policy issues on long-term care financing, including information on the characteristics of the elderly and their need for and utilization of long-term care services.

We believe this report will be extremely helpful to the Members of the Energy and Commerce Committee in their understanding of the gaps in long-term care coverage and options for reform of the current financing system. In particular, the report should be of great value as a resource document for hearings to be held and legislation on this subject to be considered, by the Subcommittee.

Sincerely,

Henry A. Waxman
Chairman, Subcommittee on
Health and the Environment

HAW/drs

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PURPOSE OF REPORT

The aging of the population of the United States has particularly important implications for the demand for health and long-term care services. The frequency of chronic illness, frailty, and disability will increase as the population ages. The health and long-term care programs in place today will be severely strained and, in some cases, unable to cope with new and growing demands.

We need to find and finance better ways of organizing and delivering long-term care services before the aging of the baby boom generation overtakes us. Today's system has serious gaps and leaves many of the elderly and disabled without assistance to finance needed care.

There is no public or private insurance for a broad range of long-term care services. Medicare pays only for limited home health and skilled nursing facility services related to acute illness. Medicaid pays for nursing home services and some community-based care, but only for those poor enough to qualify for assistance. Medicaid is a means tested program for the impoverished elderly which cannot and does not meet the needs of the near-poor or the frail elderly struggling in the community. Other programs, like Title XX or services under the Older Americans Act, provide important, but extremely limited, services to the frail and disabled. Despite these efforts, long-term care is still the major catastrophic burden that most elderly Americans and their families face.

With the aging of the population, we must look to the future and begin to lay the foundation for the nation's forthcoming needs. We cannot expect a fragmented and piecemeal approach to provide a satisfactory solution to growing demands. Nor can we expect the private sector to save us from facing the future. We must examine the current ways in which we finance and deliver long-term care, recognize the problems of our current approach, and fashion options to resolve the major problems.

To help the Members of the Committee to examine and understand the current system and its problems, we asked the Congressional Research Services (CRS) of the Library of Congress to assemble background information. The document which follows includes: (1) a description of the characteristics of the elderly and their need for long-term care services; (2) a description of the public programs that finance long-term care, inlcuding background on demonstration projects to test alternative delivery and financing approaches; (3) a description of long-term care coverage available through the

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private sector; and (4) a discussion of the major issues to be addressed in long-term care reform.

The Committee wishes to thank Carol O'Shaugnessy, Richard Price and Jeanne Griffith of the Congressional Research Service who prepared this report.

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ABSTRACT

This report provides an overview of selected policy issues on long-term care financing, including information on characteristics of the elderly and their need for and utilization of long-term care services, and a review of public sector programs and private sector approaches to financing long-term care services.

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EXECUTIVE SUMMARY

The projected growth of the elderly population, combined with large and increasing Federal and other public expenditures for long-term care services, and especially nursing home services, has generated substantial interest in altering the way in which long-term care services are financed and delivered. In the past, legislative interest has focused in part on coordination of existing Federal programs financing long-term care in order to offer more consistent and adequate protection for the potentially catastrophic expenditures the elderly can incur as the result of chronic illness. In addition, policy-makers have also sought ways to expand community-based services to correct what some perceive to be a bias in the current system in financing institutional long-term care. This report provides an overview of selected policy issues on long-term care financing, including information on characteristics of the elderly and their need for and utilization of long-term care services, and a review of public sector programs and private sector approaches to financing long-term care services.

The phrase "long-term care" refers to a wide array of medical, social, personal, and supportive services needed by individuals who have lost some capacity for self-care due to chronic illness or physical or mental conditions which result in both functional impairment and physical dependence on others for an extended period of time. Major subgroups of individuals needing long-term care include the elderly and non-elderly disabled, the developmentally disabled (primarily the mentally retarded), and the mentally ill. This report focuses principally on long-term care services required by the elderly, generally those persons 65 years and older. Elderly persons, by virtue of their high risk of chronic illness that results in disability and functional impairment, are the primary recipients of long-term care in this country.

The range of chronic illnesses and conditions resulting in the need for supportive long-term care services is extensive. Unlike acute illnesses, which occur suddenly and are usually resolved in a relatively short period of time, chronic conditions are of an extended duration and may be difficult to treat medically except to maintain the status quo of the patient. Although chronic conditions occur in individuals of all ages, their incidence, especially as they result in disability, increases with age. These conditions may include heart disease, strokes, arthritis, and vision and hearing impairments. Dementia, the chronic, often progressive loss of intellectual function, is also a major cause of disability in the elderly. At least half and perhaps as many as 70 percent of patients with dementia have Alzheimer's disease, a chronic, progressive,

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primary neurologic degeneration of unknown cause, which increases in prevalence with advancing age and for which there is currently no effective treatment.

Long-term care services include a wide variety of health and social services provided in an institution, in the community, or in the home. Services range from medical and therapeutic services for the treatment and management of chronic illness provided by skilled personnel to assistance with basic activities of daily living, such as housekeeping and personal care services, provided by family members, nurses, and social workers. By far, the majority of long-term care services are provided by family members.

Based on the projected growth of the elderly population and current utilization patterns of institutional and community long-term care services, major increases in the demand for long-term care can be anticipated for the future. Today approximately 1.2 million elderly persons are residents of nursing homes. This is about five percent of the total elderly population. With current utilization, the National Center for Health Statistics has estimated that the number of elderly nursing home residents will increase by 58 percent from 1978 to 2003 when constant mortality is assumed and by over 115 percent when declining mortality is assumed. In addition, for every person 65 years of age and over residing in a nursing home, there are twice as many persons living in the community requiring the various kinds of care provided in an institution.

At least 80 Federal programs assist persons with long-term care problems, either directly or indirectly through cash assistance, in-kind transfers, or the provision of goods and services. Among these 80 programs, five are generally considered to be the major programs of Federal support for long-term care: Medicaid, Medicare, the Social Services Block Grant, the Older Americans Act, and the Supplemental Security Income program. No one program, however, has been designed to support a full range of long-term care services on a systematic basis.

For example, the Medicare program is intended to address the acute medical care needs of the aged and disabled. To the extent that it provides coverage for certain long-term care services, it does so with the intent of reducing the need for more intensive and expensive acute care serivces. The program was not designed to respond specifically to the chronic care needs of the elderly, for instance those with Alzheimer's disease, over a sustained period of time.

The Medicaid program on the other hand, does support long-term services, principally nursing home care, but only for certain low-income people or for persons who have depleted their income and assets. Many persons become eligible for Medicaid's nursing home benefit only after they have depleted their income and assets on sizable out-of-pocket expenditures for long-term care.

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The Social Services Block Grant program, by way of contrast, is generally limited to the provision of community-based social services selected and defined by the State. This program may cover medical care only when it is integral but subordinate to the provision of a social service. Funding under title III of the Older Americans Act is used for the development of a service delivery system for older persons, focusing on social and nutritional services. The Supplemental Security Income program provides cash assistance to needy aged, blind, and disabled individuals.

In addition, varying eligibility requirements, service benefits, service definitions, and reimbursement policies among these five major Federal programs supporting long-term care have resulted in a fragmented and uncoordinated longterm care policy at the Federal level. This lack of coordination among Federal programs has also presented major implementation challenges to the States, especially where certain of these programs delegate administrative responsibility to State governments.

The following chart summarizes some of the major differences among Federal programs which support institutional and community-based care.

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Major Federal Programs Supporting Long-Term Care Services:
Services Covered, Eligibility, and Administering Agency

Program	Services covered	Eligibility	Administering agency	
			Federal	State
Medicaid/ Title XIX of the Social Security Act	Skilled nursing facility a/ Intermediate care facility b/ Home health c/ Adult day care b/	Aged, blind, disabled persons receiving cash assistance under SSI; others receiving cash assistance under AFDC. At State option, persons whose income exceeds standards for cash assistance under SSI/AFDC, i.e., the "medically needy."	Health Care Financing Administration/ HHS	State Medicaid agency
	2176 "waiver" services, e.g., case management, homemaker, personal care, adult day care, habilitation, respite, and other services at State option. d/	Aged, blind, disabled, or mentally ill Medicaid eligibles (including children) living in the community who would require nursing home level care. At State option, persons living in the community with higher income than normally allowed under a State Medicaid plan.		In some cases, the 2176 "waiver" program may be administered by another agency, e.g., State agency on aging.

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Major Federal Programs Supporting Long-Term Care Services:
Services Covered, Eligibility, and Administering Agency--Continued

Program	Services covered	Eligibility	Administering agency	
			Federal	State
Medicare/ Title XVIII of the Social Security Act	100 days of skilled nursing facility care Home health Hospice	Generally Social Security status. Persons 65 years and over; persons under 65 years entitled to Federal disability benefits; and certain persons with end-stage renal disease.	Health Care Financing Administration/ HHS	N/A
Social Services Block Grant/Title XX of the Social Security Act	Various social services as defined by the State, including homemaker, home health aide, personal care, home-delivered meals	No Federal requirements. States may require means tests.	Office of Human Development Services/HHS	State social services/human resources agency. In some cases other State agencies may administer a portion of title XX funds for certain groups, e.g., State agency on aging.

Major Federal Programs Supporting Long-Term Care Services:
Services Covered, Eligibility, and Administering Agency--Continued

Program	Services covered	Eligibility	Administering agency	
			Federal	State
Older Americans Act/ Title III	Variety of social services as determined by State and area agencies on aging, with priority on in-home services. Also case management, day care, protective services. Separate appropriation for home-delivered meals.	Persons 60 years and over. No means tests, but services are to be targeted on those with social or economic need.	Administration on Aging/Office of Human Development Services/ HHS	State agency on aging
Supplemental Security Income/ Title XVI of the Social Security Act	Federal income support. Maximum Federal payment for persons with no income is $325 per individual and $488	Aged, blind, disabled persons who meet Federally established income and resources requirements. States may make payments to	Social Security Administration/ HHS	State supplemental payment program may be State or Federally administered.

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Major Federal Programs Supporting Long-Term Care Services:
Services Covered, Eligibility, and Administering Agency--Continued

Program	Services covered	Eligibility	Administering agency	
			Federal	State
Supplemental Security Income/Title XVI of the Social Security Act (cont'd)	per couple in 1985. Supplemental payment for non-medical housing and/or in-home services, as determined by State.	other State-defined eligibility groups.		

a/ Required for individuals over age 21.

b/ At option of State.

c/ Required for individuals entitled to skilled nuring home care.

d/ May be offered under a waiver of Medicaid State plan requirements, if requested by the State and approved by HHS. May include waiver of Medicaid eligibility requirements and stipulation that services be offered on a statewide basis.

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Policymakers have also been concerned about striking the right balance between nursing home care services and home and community-based long-term care services. By far the largest portion of public expenditures for long-term care is for nursing home care, with the Medicaid program accounting for 43 percent of total national spending for nursing home care. Other programs, such as the Social Services Block Grant and the Older Americans Act, while providing a range of community-based long term care services, have limited ability to provide a balance to the enormous institutional support provided through the Medicaid program. Long-term care reform in the past, therefore, has included efforts to reduce inappropriate institutionalization of the chronically ill by creating programs to assure that those referred for institutional care actually need such care and by increasing the availability of community-based care services, such as home care and adult day care services.

Various Federal research and demonstration projects have attempted to test new ways of providing and coordinating long-term care services. These have included projects to develop case management and assessment procedures to better target services to those most at risk of institutionalization, and to create new community-based service options. Some of these projects have led to the initiation of the National Long-Term Channeling Demonstration program by the Department of Health and Human Services (DHHS). The Channeling Demonstration was designed to test whether a carefully managed approach to the provision of community-based long-term care services to a frail elderly population living outside institutions could help control overall long-term care costs while maintaining or improving the well-being of clients. Another major research and demonstration initiative of DHHS currently underway is the social/health maintenance organization (S/HMO). This project builds upon and extends the health maintenance organization model, where health care services are offered to a defined population on a pre-paid capitation basis. The S/HMO provides not only conventional health care services to a group of elderly persons but also provides a range of long-term care services including nursing home care, home health, and homemaker services. Among the questions to be addressed by this demonstration are whether a consolidated pre-paid system of acute and long-term care can produce greater savings than conventional HMOs already serving Medicare beneficiaries, and whether the long-term care services offered through the program will reduce nursing home admissions and the number of persons who become eligible for Medicaid's nursing home benefit after they have depleted their income and assets on expenditures for long-term care.

Uncertainty about the potential costs of expanded community-based care, and intervening concern about budget deficits and increasing expenditures under entitlement programs which currently finance long-term care, have shifted the focus of the long-term care debate to consideration of private sector initiatives which might relieve fiscal pressures on public programs and which, at the same time, might improve the elderly's ability to finance long-term care. Some of the private sector options advanced as feasible alternatives for financing long-term care include private health insurance, life

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care communities, and home equity conversion. Not discussed in this report are other options often suggested as alternative financing mechanisms for longterm care, including the various tax code amendments proposed to encourage families to continue providing long-term care services.

Currently, relatively few insurance companies (studies indicate 16 to 25) write long-term care insurance policies which are substantially more comprehensive than standard policies supplementing Medicare coverage. It is estimated that only about 50,000 elderly persons are presently insured under such plans. A number of barriers have been cited as impediments to the development of meaningful long-term care insurance policies, such as the potential for adverse selection (where only persons more likely to need long-term care buy insurance) and induced demand (where individuals decide to use more services because they have insurance and/or will shift from non-paid providers, such as family members, to paid providers of care). Recent research, however, suggests that some of these barriers may be resolved in a number of ways, including expanding the pool of the insured by encouraging people to buy at younger ages.

Life care communities, also called continuing care retirement communities, are living arrangements available to a limited but potentially growing number of older persons. Such communities are established to provide housing, meals, housekeeping, and certain long-term care services, as necessary, to older persons for the duration of their lives. Older persons enter into a contractual agreement which sets forth the services to be received by the resident in exchange for financial payments, including an entrance fee and monthly payments. The number of existing life care communities is estimated to range from 300 to 600, but this number is expected to more than double in this decade. Supporters of this concept indicate that a life care contract provides financial protection against the future costs of long-term care and offers a protective living arrangement for persons whose needs will increase over time. However, because of the substantial fees required for entrance, some analysts believe this option may be available to only a limited proportion of the elderly population.

Home equity conversion contracts, in which older persons use the equity in their homes to finance certain expenses, have also been advanced as a means to finance certain long-term care services. While substantial numbers of elderly persons have accumulated equity in their homes, to date only a very limited number (estimates of about 300-400 at most) of home equity conversion contracts have been negotiated.

Observers have pointed out that the economic status of future generations of the elderly may improve to the extent that they will be able to finance, through risk pooling arrangements, at least a portion of their long-term care expenses themselves, without resorting to the impoverishment currently required under Medicaid to qualify for that program's nursing home benefit. In addition, others have noted that public programs will simply not be able to support

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expanded long-term care services in the future as the ratio of workers to retireec declines and as the number of the very oldest segment of the population increases. For the time being, however, these options appear to provide only limited opportunities for alternative financing schemes for long-term care. In addition, they seem to have only limited applicability for the large numbers of elderly who are poor or may be poor in the future.

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LONG-TERM CARE FOR THE ELDERLY

I. INTRODUCTION

The phrase "long-term care" refers to a wide array of medical, social, personal, and supportive services needed by individuals who have lost some capacity for self-care due to chronic illness or physical or mental conditions which result in both functional impairment and physical dependence on others for an extended period of time. Major subgroups of individuals needing long-term care include the elderly and non-elderly disabled, the developmentally disabled (primarily the mentally retarded) and the mentally ill. This report focuses principally on long-term care services required by the elderly. Elderly persons, by virtue of their high risk of chronic illness that results in disability and functional impairment, are the primary recipients of long-term care in this country. 1/

The range of chronic illnesses and conditions resulting in the need for supportive long-term care services is extensive. Unlike acute illnesses, which occur suddenly and are usually resolved in a relatively short period of time, chronic conditions are of an extended duration and may be difficult to treat medically except to maintain the status quo of the patient. Although chronic conditions occur in individuals of all ages, their incidence, especially as they result in disability, increases with age. 2/ These conditions may include heart disease, strokes, arthritis, and vision and hearing impairments. Dementia, the chronic, often progressive loss of intellectual function, is also a major cause of disability in the elderly. 3/ At least half and perhaps as many as 70 percent of patients with dementia have Alzheimer's disease, a chronic progressive primary neurologic degeneration of unknown cause, which

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1/ Doty, Pamela, Korbin Liu and Joshua Wiener. An Overview of Long-Term Care. Health Care Financing Review, v. 6, no. 3, spring 1985. p. 69.

2/ Rice, Dorothy and Carroll Estes. Health of the Elderly: Policy Issues and Challenges. Health Affairs, v. 3, no. 4, winter 1984. p. 29.

3/ Rowe, John. Health Care of the Elderly. New England Journal of Medicine, v. 312, no. 13, Mar. 28, 1985. p. 831.

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which increases in prevalence with advancing age and for which there is currently no effective treatment. 4/

The presence of a chronic illness or condition alone does not necessarily result in a need for long-term care. For many individuals, their illness or condition does not result in a functional impairment or dependence and they are able to go about their daily routines without major hindrance or need for assistance. 5/ It is when the illness or condition results in a functional or activity limitation that long-term care services may be required. Limitations can vary in severity and prevalence. For example, a chronic condition may result in dependence in certain basic self-care functions such as bathing, dressing, eating, toileting, and/or mobility from one place to another. These are referred to as limitations in "activities of daily living" (ADLs). A second set of measures reflecting lower levels of disability in the performance of a daily routine are often referred to as limitations in "instrumental activities of daily living" (IADLs). 6/ These include such functions as shopping, cooking, cleaning, managing money, and taking medicine. For example, certain individuals may not have limitations in basic self-care functions, but may not be able to clean or shop without some kind of assistance. Other individuals may suffer from a chronic condition or multiple conditions resulting in limitations in both ADLs and IADLs and therefore require a number of specific long-term care services.

Long-term care services include a wide variety of health and social services provided in an institution, in the community, or in the home. Services range from medical and therapeutic services for the treatment and management of chronic illnesses and conditions to assistance with basic living services associated with shelter and meals, such as housekeeping and shopping, to personal care assistance, such as bathing, grooming, and toileting. Such services are generally provided by nurses, social workers, therapists, and a wide variety of unskilled personnel, such as homemakers, nurses aides, and volunteers. Community-based services can be provided formally by agencies or organizations that are paid for their services, or informally by family or friends who offer assistance without compensation. By far, the great majority of long-term care is provided informally by family or friends.

4/ Rowe, p. 831.

5/ Long Term Care: Background and Future Directions. Health Care Financing Administration, Department of Health and Human Services, Jan. 1981, HCFA 81-20047. p. 4.

6/ Liu, Korbin and Kenneth Manton. Disability and Long-Term Care. A paper presented at the Methodologies of Forecasting Life and Active Life Expectancy Workshop. Bethesda, Maryland, June 25-26, 1985.

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The projected growth of the elderly population, combined with large and increasing Federal and other public expenditures for long-term care services, and especially nursing home services, has generated substantial legislative interest in altering the way in which long-term care services are financed. This report discusses the financing of long-term care services, and especially the extent to which various Federal programs cover and fund these services. It also describes various proposals that have been advanced as alternative private financing schemes for long-term care.

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II. SELECTED CHARACTERISTICS OF THE ELDERLY AND MEASURING THEIR NEED FOR LONG-TERM CARE

The need for long-term care services in the future will depend on a number of factors, including demographic changes in the Nation's population, economic conditions which affect an individual's ability to pay for services, levels of disability, and medical advances in the prevention and treatment of chronic conditions. Estimating the dimension of the need for long-term care is a difficult but critical task for policymakers. It is critical since large and increasing amounts of public dollars finance long-term care services. It is difficult because the impact of certain of these factors cannot be predicted with certainty. For example, medical advances may result in the prevention of certain chronic conditions, or simply in incremental improvements in their management. Medical and scientific advances can also lead to reductions in general mortality which would result in increases in the size of the potential long-term care population. This section provides information about certain demographic and income characteristics of the elderly population.

A. Growth of the Elderly Population

The aging of the Nation's population has dramatic implications for projections of need for long-term care services. The elderly population has grown much more rapidly in this century than has the remainder of the population. As table 1 shows, from 1900 to 1950, the total population doubled in size while the population aged 65 and over increased by four times; from 1950 to 1980, when the total population increased by 50 percent, the aged population doubled in size, to 25.5 million. Between 1980 and the year 2020, the total population is projected to increase by slightly more than 30 percent, while the elderly population is projected to more than double again. By 2020, the projected elderly population will be 51.4 million, 17.3 percent of the total population.

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TABLE 1. Size of the Elderly Population, 1900 to 2020
(in thousands)

Year	Total U.S. population	65+		85+		Aged support ratio*
		No.	%	No.	%	
1900	76,303	3,084	4.0	123	0.2	7.6
1950	150,697	12,270	8.1	577	0.4	13.7
1980	226,505	25,544	11.3	2,240	1.0	18.6
2000	267,955	34,921	13.0	4,926	1.8	21.6
2020	296,597	51,422	17.3	7,081	2.4	29.3

* Ratio of 65+ plus population to working age population, 19-64 years, multiplied by 100.

Source: U.S. Department of Commerce. Bureau of the Census. Decennial Censuses of Population 1900-1980 and Projections of the Population of the United States by Age, Sex, and Race: 1983 to 2080 (Advance Report). Current Population Reports, Series P-25. No. 952. May 1984. Projections are middle series.

As a result of the rapid increase in the elderly population, their proportion of the population increased from 4.0 percent in 1900 to 11.3 percent in 1980; this is expected to increase to 13.0 percent by 2000. At the same time, the number of elderly in comparison to the number of persons in the working age population (persons aged 19-64) has increased substantially. The aged support ratio (that is, the ratio of the 65+ population to the working age population 19-64 years) increased from 7.6 in 1900 to 18.6 in 1980 and is expected to increase to 29.3 by 2020.

Despite the overall growth in the 65 plus group, the most critical demographic factor with implications for the future of long-term care service utilization is the startling pace of increase in the oldest segment of society. The "old-old," persons 85 and over, are currently the fastest growing age group in the U.S. population. This group represented only 0.2 percent of the total population in 1900, but increased to 1.0 percent in 1980; by 2020, they are projected to be 2.4 percent of the population, and nearly 14 percent of the elderly population (up from about 9 percent in 1980).

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B. Economic Characteristics of the Elderly

1. Income

In 1984, the median income of families headed by persons 65 or older was $18,215; the median income of an unrelated individual in the same age group was $7,296. (There were 9.8 million such families and 7.3 million such unrelated individuals.) 7/ This compares to $24,433 for all families and $11,204 for all unrelated individuals. Data from the 1980 Census of Population and Housing show that the cash income of the elderly is lower in each older age group. 8/ Married couples with a head aged 65-69 had median incomes of $18,400, compared to $11,200 for those 85 and over. Men aged 65 to 69 and living alone had median incomes of $8,200, while those 85 and over had incomes of $6,000; the comparable figures for women living along were $6,800 and $5,200, respectively. In 1983, the after-tax, disposable income of elderly households, adjusted for family size, was less than that of households with heads aged 50 to 64, but higher than all other households. 9/ Among the younger old, and particularly among those who will become old in the next decade, pension coverage is higher than was the case for the old-old. At the same time, early retirement is an increasingly common phenomenon.

2. Poverty Rates

The poverty rates for the elderly have shown a dramatic decline over the last 25 years. In 1959, the poverty rate for the elderly was 35.2 percent and by 1984 the rate had fallen to 12.4 percent, the lowest rate ever recorded for that group. In addition, from 1982 to 1984, the poverty rates among the elderly population in general have been lower than those of the rest of the population. In 1984, 12.4 percent of those 65 and over were poor in comparison to 14.4 percent of the entire population. (In 1984, the estimated poverty threshold for persons 65 years and over was $4,979, and for two person families whose head was 65 years and over, it was $6,282.) These aggregate figures, however, mask important differences within

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7/ U.S. Bureau of the Census. Current Population Reports. Series P-60, no. 149. Money Income and Poverty Status of Families and Persons in the United States: 1984 (Advance Data from the March 1985 Current Population Survey). U.S. Govt. Print. Off., Washington, D.C., 1985. p. 12.

8/ U.S. Bureau of the Census. 1980 Census of Population and Housing. Public Use Microdata Sample. Special tabulations.

9/ U.S. Bureau of the Census. Current Population Reports. Series P-23, no. 143. After-Tax Money Income Estimates of Households: 1983. U.S. Govt. Print. Off., Washington, D.C., 1985. p. 31.

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both the elderly and the remainder of the population. The poverty rate among other adults (persons 22 to 64), for example, was 11.1 percent in 1984; the rate for the entire population is inflated by the very high rates of poverty among children. 10/

There are specific groups among the elderly that are at substantially greater risk of poverty. Poverty rates increase sharply with age; in 1980, the rates varied from 13.6 percent among those 65 to 69 to 27.3 percent among those 85 and over. Women have rates that are two to three times as high as men; women 85 and over had poverty rates of 34.1 percent compared to 17.2 percent among men. Finally, elderly who live alone have much higher rates than do persons living with a spouse or with children. People aged 85 and over living alone in 1980 had a poverty rate of 36.8 percent, in contrast to a rate of 12.4 percent among those living with a spouse. 11/ In all cases, the poverty rates are much lower among the young-old (persons 65-74 years of age).

3. Assets

In 1979, the assets of the elderly, including equity in their homes and automobiles as well as other financial assets, also varied by age group. Households with heads aged 65 to 69 on average had more assets ($89,200) than households with heads 70 and over ($73,800). The age group that will become elderly in the next decade, those 55 to 64, had a higher level of assets ($110,200) than their immediate seniors, and also a higher level than younger age groups ($77,600 for those 45 to 54 and $68,500 for those 35 to 44). 12/ Beginning with those aged 55 to 64, an increasing share of assets are in the form of home equity. This ranges from just under 40 percent of assets among those aged 55 to 64 to nearly 50 percent among those 70 and over.

4. Future Resources

A number of sources indicate that in the future, the new elderly will have increasingly higher incomes and assets. These predictions may have implications for the ability of the elderly to finance long-term care. Median income among the elderly as a whole has been projected to rise (controlling for inflation) from 10 to 20 percent

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10/ Money Income and Poverty Status of Families and Persons in the United States: 1984. p. 26 and p. 31.

11/ The 1980 Census of Population and Housing. Ibid.

12/ Torrey, Barbara Boyle. The Visible Costs of the Invisible Aged: The Fiscal Implications of the Growth in the Very Old. A paper presented at the annual meeting of the American Association for the Advancement of Science, May 1984.

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from 1980 to 1995 (assuming 1.0 to 1.5 percent average annual growth in income among the general population). 13/ Under the same growth assumptions, income among persons 55 to 64 is projected to increase from between 15 and 20 percent in the same period. Asset levels are even more difficult to project, but because of the improved historical personal economic experiences of the future aged who have lived through the post-World War II prosperity, some anticipate that their levels of resources will be considerably greater than past generations of elderly. 14/

Although the relative well-being (measured with income and assets) of the future elderly may on average be greater than that of recent generations of elderly, there will also continue to be large differences among the various groups of the elderly. Some of the differences will be the same as those described above, based either on lifetime differences of individuals or on sudden or gradual changes in family status or available sources of income and assets. Even if poverty rates are substantially lower than they currently are, there may be more poor elderly than there are now, because of the increasing numbers of elderly people. For example, if poverty rates among the elderly drop 20 percent by the year 2000, to 10.0 percent (from the current 12.4 percent), there would still be 3.5 million poor elderly--compared to 3.3 million in 1984. If poverty rates were to remain constant, there would be 4.3 million poor elderly in 2000. These factors will continue to exert pressure on public sector long-term care programs.

C. Utilization of Institutional and Community-Based Long-Term Care Services

Based on the projected growth of the elderly population and current utilization patterns of institutional and community long-term care services, major increases in the demand for long-term care can be anticipated for the future. Today approximately 1.2 million elderly persons are residents of nursing homes. This is about five percent of the total elderly population. With current utilization, the National Center for Health Statistics has estimated that the number of elderly nursing home residents will increase by 58 percent

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13/ U.S. Bureau of the Census. Current Population Reports. Series P-60, no. 122. Illustrative Projections of Money Income Size Distributions for Households: 1980 to 1995. U.S. Govt. Print. Off., Washington, D.C., 1980. Series C. 1.0 and 1.5 percent growth in household income.

14/ Etheredge, Lynn. An Aging Society and the Federal Deficit. Milbank Memorial Fund Quarterly/Health and Society, v. 62, no. 4, 1984. p. 527.

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from 1978 to 2003 when constant mortality is assumed and by over 115 percent when declining mortality is assumed. 15/

The rates of nursing home utilization are most dramatic when broken down by age group. The old-old (those 85 years and over) show much higher nursing home utilization rates than their younger counterparts. As table 2 shows, for women 85 years and over the rate of nursing home use per 1000 population is 251.5 as compared to only 15.9 for females 65-74, and 80.6 for females 75-84. A similar pattern exists for men, although their nursing home utilization rates are lower.

TABLE 2. Age-Specific Rates of Nursing Home Utilization per 1,000 Population, by Sex

Sex and age	Rates per 1,000 population Nursing home residents
Male	
65-74	12.7
75-84	47.4
85+	140.0
Total 65+	30.7
Female	
65-74	15.9
75-84	80.6
85+	251.5
Total 65+	59.7

Source: Rice, Dorothy and Jacob J. Feldman. Living Longer in the United States: Demographic Changes and Health Needs of the Elderly. Milbank Memorial Fund Quarterly/Health Society, v. 61, no. 3, 1983. Table 6. p. 376. Data are from the National Nursing Home Survey of 1977.

For every person 65 years of age and over residing in a nursing home, there are twice as many persons living in the community

15/ Changing Mortality Patterns. Health Services Utilization and Health Care Expenditures: United States 1978-2003, Analytical and Epidemiological Studies Series 3, no. 23, National Center for Health Statistics, Department of Health and Human Services, Pub. No. (PHS) 83-1407, Sept. 1983. p. 20.

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requiring similar levels of care. 16/ The 1979 National Health Interview Survey found that 12 percent of the population age 65 and over needed the help of another person in carrying out everyday activities and managed to live in the community despite chronic disability. 17/ Preliminary analysis from the 1982 National Long-Term Care Survey found approximately 4.6 million non-institutionalized elderly Americans, or 18 percent of the over 65 population, had limitations in ADLs and IADLs. 18/ As discussed above, limitations in ADLs reflect dependence in certain basic self-care functions such as bathing, dressing, eating, etc., and limitations in IADLs refer to lower levels of disability in the performance of a daily routine, including shopping, cooking, and cleaning. The 1982 Long-Term Care Survey found that two-thirds of the 4.6 million disabled non-institutionalized elderly living in the community were moderately impaired with one or two ADL limitations or only IADL limitations. About 850,000 elderly individuals were residing in the community with severe limitations (five or six ADLs).

This same preliminary analysis found that most of these disabled elderly received personal assistance in activities of daily living from spouses, children or other informal sources of support. 19/ Of the 4.6 million disabled elderly in the community, almost 70 percent relied exclusively on nonpaid sources. This finding corresponds to other research that has estimated that between 60 and 80 percent of the care received by the impaired elderly is provided by relatives and friends who are not compensated. 20/

It should be noted that the aging of the Nation's population has important implications for the availability of informal family sources of support for long-term care. Because of differences in mortality at all ages, older women are much more likely to be widowed than older men and are, therefore, at greater risk of institutionalization. In 1983, 9.0 percent of men aged 65 to 74 were widowed in contrast to 39.2 percent of women. The difference increases with

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16/ Doty, Pamela, Korbin Liu, and Joshua Wiener. An Overview of Long-Term Care. Health Care Financing Review, v. 6, no. 3, spring 1985. p. 70.

17/ Feller, Barbara. Americans Needing Help to Function at Home. National Center for Health Statistics Advance Data, no. 92, Sept. 14, 1983. p. 7.

18/ Liu, Korbin, Kenneth Manton, and Barbara Liu. Home Care Expenses for Non-institutionalized Elderly with ADL and IADL Limitations. Unpublished paper, Apr. 23, 1985. p. 9.

19/ Liu, Manton, and Liu, p. 9.

20/ Long-Term Care: Background and Future Directions. Health Care Financing Administration, Department of Health and Human Services. Jan. 1981, HCFA 81-20047.

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age: among persons 75 and over, 21.7 percent of men and 66.6 percent of women were widowed.

In addition, the ability of children to support disabled parents may diminish. As the population ages, very old chronically ill parents with children who themselves are retired or chronically impaired become more common. 21/ Researchers have noted that the probability of young elderly (aged 65-69) women having at least one surviving parent aged 85 or older will more than double over the next 60 years. 22/ In addition, increased participation by women in the labor force may also decrease the amount of time they can spend on informal care of their relatives. Gerontologists have also noted the stress experienced by certain caretakers who have multiple roles--participation in the labor force and caretakers of children as well as disabled relatives.

21/ Long-Term Care: Background and Future Directions. p. 12.

22/ Soldo, Beth J. and Kenneth G. Manton. Health Status and Service Needs of the Oldest Old: Current Patterns and Future Trends. Milbank Memorial Fund Quarterly/Health and Society, v. 63, no. 2, spring 1985. p. 310.

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III. PUBLIC SECTOR PROGRAMS FOR FINANCING AND DELIVERY OF LONG-TERM CARE SERVICES

Implicit in any discussion of long-term care policy is the fact that large amounts of public dollars currently finance long-term care services, and that even greater amounts will be spent in the future as the elderly population, especially the very old, increases. Aggregated data on spending for all nursing home and non-institutional long-term care services under the complete array of Federal, State and local programs are not easily available. At least 80 Federal programs assist persons with long-term care problems, either directly or indirectly through cash assistance, in-kind transfers, or the provision of goods and services. In addition, differences in definitions of services to be included in long-term care and inconsistent reporting across programs make aggregation of expenditure data very difficult.

However, it is generally agreed that most of the public sector's expenditures for long-term care services are for nursing home or other institutional care. In 1983, nearly $29 billion was spent nationally for nursing home care, accounting for 8.5 percent of total personal health care expenditures. Almost 50 percent ($14 billion) of nursing home expenditures was financed by Federal, State, and local governments.

By far the largest portion of public expenditures for nursing home care is financed by the Medicaid program for the poor and medically indigent. In 1983, Federal, State, and local Medicaid expenditures for nursing home care amounted to $12.4 billion. This represented 43 percent of total national spending on nursing home care and 89 percent of public spending for nursing home care in 1983. Medicaid's expenditures for nursing home care also represented a significant portion of total Medicaid spending. In 1983, Medicaid nursing home expenditures amounted to about 43 percent of total Medicaid spending for all health services covered under the program. In addition, an analysis of Medicaid expenditures found that 27 States spent 50 percent or more of their Medicaid budgets on nursing home care in 1982. 23/

23/ Short-Term Evaluation of Medicaid: Selected Issues. Department of Health and Human Services, Health Care Financing Administration, Office of Research and Demonstrations, no. 84-9. July 1, 1984.

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By way of contrast, the Medicare program for the aged and disabled accounts for only a small portion of the Nation's expenditures for nursing home care.

Medicare's expenditures amounted to $500 million and represented less than 2 percent of national spending and 3.6 percent of public spending for nursing home care in 1983.

Expenditures for non-institutional community-based services are relatively small compared to spending for nursing home services. Whereas nursing home care accounted for about 43 percent of total Medicaid expenditures for health care services in 1983, home health care accounted for only 1.8 percent of total Medicaid spending in that year and amounted to approximately $600 million. In only 11 States did home health benefits constitute more than one percent of total Medicaid expenditures. One State (New York) alone accounted for nearly 80 percent of total Medicaid home health expenditures.

Medicare's expenditures for home health benefits are also a small proportion of total expenditures. In 1983, they amounted to $1.5 billion, or 2.7 percent of total program expenditures.

It should be noted that while its share remains small, home health care has become one of the fastest growing components of both the Medicare and Medicaid budgets. Between 1974 and 1983, home health care expenditures under Medicare increased from $119 million to $1.5 billion. This represented a 32.5 percent annual compound rate of growth. Medicaid expenditures for home health also increased rapidly--from $31 million in 1974 to $600 million in 1983, a 39 percent annual compound rate of growth.

While the Medicaid program is the predominant Federal program supporting long-term care services, a variety of social service programs provide communitybased services which may prevent or delay institutionalization. Chief among these are the Social Services Block Grant program and the Older Americans Act. While their total resources are small in comparison with total Medicaid expenditures devoted to long-term care, in many communities they represent an important source of service to the frail elderly or fill gaps in services not met by either the Medicare or Medicaid programs.

Virtually all States provide a number of home and community-based long-term care services for diverse client groups, including children, disabled, and the elderly, through the Social Services Block Grant (SSBG) program under title XX of the Social Security Act. Such services may include homemaker, home health aide, chore, and adult day care services. In some recent years expenditures for homemaker services alone have represented the second or third largest service expenditure category under the program. In addition, the increase in homemaker service expenditures from 1979 to 1980 (from $391.6 million to $410.9 million) was attributed to expanded use of funds for the elderly. For FY 1980 the average number of persons receiving this service was over 275,000 per quarter. Because Federal reporting requirements for services supported by the program have

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been eliminated, more recent national data on total expenditures and persons served are unavailable.

Home care, including homemaker, chore, and personal care services, is one of the major service categories under title III of the Older Americans Act. For FY 1984, it was estimated that the program would support over two million home care visits to the elderly. The Older Americans Act also authorizes a home-delivered meals program, with $62 million appropriated for FY 1984. An estimated 67 million home-delivered meals were served under auspices of the program during FY 1984.

A. Major Federal Programs and Activities Supporting Long-Term Care Services

As noted above, at least 80 Federal programs assist persons with long-term care problems, either directly or indirectly through cash assistance, in-kind transfers, or provision of goods and services. These programs often respond in a manner that is problem-specific, categorical in nature, or targeted at specific client groups. For example, certain programs provide health services while excluding social services; others are oriented to the elderly to the exclusion of the younger disabled. Some programs carry income eligibility requirements, others do not.

This section describes selected Federal programs--Medicaid, Medicare, the SSBG, Older Americans Act, and Supplemental Security Income (SSI) programs--which address the health and social services needs of the elderly population. Taken together, these programs constitute the major focus of Federal financial support presently available for both community-based and the institutional long-term services. The differing characteristics of these programs reflect what some observers point out to be the uncoordinated nature of Federal support for long-term care services.

Not discussed here are a host of other Federal programs dealing with such components of the long-term care spectrum as housing, transportation, tax policy as well as services provided through the Veterans Administration (VA). It should be noted, however, that numerous long-term care benefits are offered to veterans through the VA, including nursing home care, domiciliary care, outpatient clinics, and adult day health services, as well as cash payments for aid and attendance for certain severely disabled veterans. Services are offered directly by the VA and are also provided on a contract basis in non-VA hospitals and community nursing homes, and on a grant basis in State veterans' home facilities. Issues surrounding the financing and delivery of long-term care services to the veteran population are of increasing concern to the VA because of the growing number of older veterans. By the year 2000, approximately two out of every three males age 65 or older will be veterans and the VA is predicting dramatic increases in the need for and utilization of various long-term care services by the veteran population.

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The discussion immediately below summarizes some of the major differences of the Medicaid, Medicare, Social Services Block Grant (SSBG), Older Americans Act, and SSI programs in their approach to health and social services in general and long-term care in specific. This discussion is followed by a more detailed description of each of these programs.

- PROGRAM GOALS. Medicaid is the major Federal program financing health care services for certain low income persons. While it provides health care benefits, and to a limited degree, medically related social services, to certain eligible persons with chronic care needs, it is not designed to support the full array of long-term care services on a systematic basis. Its principal form of support for long-term care services is for nursing home care. Medicare, on the other hand, is a nationwide health insurance program for the aged and disabled and is intended primarily to address acute medical care needs. To the extent that it provides coverage for certain long-term care services, it does so with the intent of reducing the need for more intensive and expensive acute care services; the program was not designed to respond specifically to chronic care needs of the elderly over a sustained period of time. The SSBG program is designed to assist families and individuals in maintaining self-sufficiency and independence; however, the program is generally limited to the provision of community-based social services selected and defined by each State and does not support institutional care. The Older Americans Act is intended to foster the development of a broadly defined, comprehensive and coordinated aging service system; however, it is limited in its ability to have a significant impact on long-term care due to its small level resources as compared to other programs. The SSI program's purpose is to provide an income floor for needy aged, blind, and disabled individuals; it provides cash payments but not services.

- ADMINISTRATIVE AUTHORITY AND FINANCING MECHANISMS. The Medicare program is administered and financed at the Federal level with uniform national standards. The Medicaid, SSBG, and Older Americans Act programs are shared Federal-State programs with States responsible for implementation of Federal legislation and regulations. The SSI program is administered by the Federal level but allows States to augment the Federal SSI payment and this portion of the program may be federally or State-administered. The Medicaid and Older Americans Act programs carry specific requirements for States to match Federal funds, whereas the SSBG does not. By virtue of their statutory obligations to beneficiaries, Medicare, Medicaid, and SSI represent uncontrollable expenditures in the Federal budget. In contrast, the total funding available for programs under the Older Americans Act is subject to an annual limit imposed through the appropriations process.

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Although the SSBG is considered an entitlement program to States, it carries a statutorily imposed Federal expenditure ceiling.

- SERVICE BENEFITS, DEFINITIONS, AND STANDARDS. As a general rule, Medicare and Medicaid provide reimbursement primarily for medical and health care services; however, in certain instances Medicaid reimbursement is available for social service components of health care services, e.g., under State options for personal care or adult day care services and under home and community-based waiver provisions. The SSBG program provides reimbursement for social services only but will provide coverage for medical care when such care is "integral but subordinate" to the provision of a social service. Funding under title III of the Older Americans Act is to be used for the development of a service delivery system for older persons, focusing on supportive and nutritional services. Recipients of SSI receive a cash payment which is federally determined but States may decide how much and for what purpose to supplement the Federal payment. Definitions for similar or complementary services vary among programs and sometimes among programs within a single State. Certain service definitions are established at the State level, or at the local level by individual service providers. Similarly, standards for services may be established upon legislative specifications.

- ELIGIBILITY. Entitlement for Medicare is generally based on Social Security status. Eligibility for Medicaid is linked to actual or potential receipt of cash assistance under the federally-assisted Aid to Families with Dependent Children program and the SSI program for the aged, blind, and disabled. The SSBG does not require that applicants or recipients meet income eligibility guidelines, although States may set standards. The Older Americans Act program prohibits income testing for services; however, funds under the program must be directed toward those with the greatest social or economic need. Eligibility for the Federal payment portion of SSI is based on federally established income and asset rules.

1. Medicaid--Title XIX of the Social Security Act

The Medicaid program is a Federal-State matching program providing medical assistance for certain low-income persons. Each State administers its own program and, subject to Federal guidelines, determines eligibility and scope of benefits. In general, each State also determines the payment rate for services provided to Medicaid recipients. The Federal Government's share of medical

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expenses is tied to a formula based upon the per capita income of the State. As a minimum, the Federal Government will pay 50 percent of the costs of medical care; this amount ranges up to 78 percent in the lower per capita income States.

The States vary greatly with regard to services they include in their plans and groups eligible to receive these services. For example, major long-term care services provided under Medicaid include intermediate care facility (ICF) services, skilled nursing facility (SNF) services, and home health services. Other Medicaid services sometimes associated with the needs of long-term care patients include: private nursing services, clinic services, physical therapy and related services, inpatient care for patients 65 years of age or older in institutions for mental diseases or tuberculosis, inpatient psychiatric services for individuals under the age of 21, personal care services at home, and adult day health services. However, not all States cover these services equally. In addition, States may cover certain other home- and community-based services under special waiver programs reviewed and approved by the Secretary of Health and Human Services.

Medicaid law requires that States cover under their programs the "categorically needy"--all persons receiving assistance under the Aid to Families with Dependent Children (AFDC) program and most persons receiving assistance under the SSI program. States may also cover additional persons as categorically needy. These might include persons who would be eligible for cash assistance, except that they are residents in medical institutions, such as skilled nursing or intermediate care facilities.

In addition to the categorically needy, States may at their option cover the "medically needy," persons whose income and resources are large enough to cover daily living expenses, according to income levels set by the State, but not large enough to pay for medical care. If the income and resources of the "medically needy" individual are above a State-prescribed level, the individual must first incur a certain amount of medical expense which lowers the income to the medically needy levels (so-called "spenddown" requirement). Thirty-four States and jurisdictions cover the medically needy. As a result of State variations such as these, persons with identical circumstances may be eligible to receive Medicaid benefits in one State but not in another; even individuals in the same State with similar incomes may not be equally eligible for benefits due to welfare rules.

Observers have noted that Medicaid's eligibility policies and benefit structure have actually created financial incentives to use nursing homes rather than community services. In general, Medicaid support to the chronically impaired elderly living in the community has usually been quite limited. In addition, certain elderly poor who are ineligible for Medicaid while living in the community may become eligible once they enter a nursing home because the State has a higher income eligibility standard for nursing home residents. Others become eligible for Medicaid once they deplete their resources

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after entering the nursing home as privately paying patients. The 1983 GAO report on "Medicaid and Nursing Home Care" noted studies showing that one-quarter to two-thirds of Medicaid patients in nursing homes initially entered as private paying patients and subsequently converted to Medicaid. 24/ Another analysis completed for the House Select Committee on Aging found that in Massachusetts 63 percent of elderly persons aged 66 and older living alone in the community will deplete their assets after only 13 weeks in a nursing home, and for married couples aged 66 years and older, 37 percent will do so within 13 weeks if one spouse requires nursing home care. 25/

In order to allow States to broaden coverage for a range of community-based services and to receive Federal reimbursement for these services, Congress in 1981 enacted new authority for the Department of Health and Human Services (DHHS) to waive certain of Medicaid's requirements. Specifically, section 2176 of the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) authorizes the Secretary of DHHS to approve "2176 waivers" for a variety of home and community-based services for individuals who, without such services, would require the level of care provided in a skilled nursing facility or intermediate care facility. Under the 2176 authority, the Health Care Financing Administration (HCFA), the DHHS agency which administers the Medicaid program, is allowed to waive two specific Medicaid requirements: (1) a requirement that Medicaid services be available throughout a State and (2) a requirement that covered services be equal in amount, duration, and scope for certain Medicaid recipients. By allowing the Secretary to waive these requirements, States are given flexibility to offer selected 2176 home and community-based services in only a portion of the State, rather than in all geographic jurisdictions as would be required absent the waiver, and to offer selected services to certain State-defined individuals eligible for Medicaid assistance, including the aged, blind, disabled, mentally retarded, and mentally ill, rather than offering such services to all persons in particular groups. In addition, States have been able to extend to waiver participants the more liberal Medicaid income eligibility rules that may be applied to persons in institutions.

The expanded services which States may offer under an approved waiver include medical and medical-related services as well as social services. Prior to the implementation of the 2176 waiver program,

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24/ Medicaid and Nursing Home Care: Cost Increases and the Need for Services are Creating Problems for the States and the Elderly. U.S. General Accounting Office, GAO/IPE-84-1. Oct. 21, 1983. p. 25-26.

25/ U.S. Congress. House. Select Committee on Aging. America's Elderly at Risk. Pub. No. 99-508, July 1985, Washington, D.C. Research analysis completed for the Committee by Dr. Laurence Branch, Dr. David Friedman, and Ms. Elinor Socholitzky.

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Medicaid services available to chronically ill or disabled individuals living in the community were generally restricted to medical and medical-related services. The waiver authority acknowledges that a wide variety of services may be needed in order to prevent or avoid institutionalization. For this reason, services traditionally considered to be social services are covered in the waiver authority. These in clude case management (commonly understood to be a system under which responsibility for locating, coordinating, and monitoring a group of services rests with a designated person or organization), homemaker and chore services, adult day health, and respite care.

The additional flexibility Congress authorized under the waiver as to services, eligibility, and geographic areas to be covered was qualified by a concern about the costs of home and community-based care to be provided under the amendment. Therefore, the law included a requirement that States demonstrate that the costs of services for individuals receiving home and community-based services not exceed the cost to Medicaid of care in institutions.

As of June 30, 1985, HCFA had approved 107 waivers in 46 States. For more information about the 2176 waiver program, see CRS white paper, Medicaid 2176 Waivers for Home and Community-Based Care, 85-817 EPW.

2. Medicare--Title XVIII of the Social Security Act

Medicare is a Federal health insurance program with a uniform eligibility and benefit structure throughout the United States. The program covers most individuals entitled to Social Security benefits, persons under 65 entitled to Federal disability benefits, and certain individuals with end-stage renal disease. Coverage is available to persons without regard to their income or assets.

Medicare is generally not regarded as a program intended to provide support for long-term care. Its coverage is focused primarily on acute care, particularly hospital and surgical care and accompanying periods of recovery. For example, Medicare covers up to 100 days of skilled nursing facility (SNF) services following a hospital stay of at least three consecutive days. The benefit is further limited in that the patient must be in need of skilled nursing care on a daily basis for treatment related to a condition for which he or she was hospitalized. The SNF benefit is subject to a daily patient copayment after the 20th day of care. The program pays for neither intermediate care facility services nor custodial care in a nursing home.

Medicare does pay for some community-based long-term care services, primarily home health services. Home health services covered under Medicare include the following:

--part-time or intermittent nursing care provided by, or under the supervision of, a registered professional nurse;

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--physical, occupational, or speech therapy;

--medical social services provided under the direction of a physician;

--medical supplies and equipment (other than drugs and medicines);

--medical services provided by an intern or resident enrolled in a teaching program in a hospital affiliated or under contract with a home health agency; and

--part-time or intermittent services provided by a home health aide, as permitted by regulations.

To qualify for home health services, the Medicare beneficiary must be confined to his/her home and under the care of a physician. In addition, the person must be in need of part-time or intermittent skilled nursing care or physical or speech therapy. Services must be provided by a home health agency certified to participate under Medicare, according to a plan of treatment prescribed and reviewed by a physician. There is no statutory limit on the number of home health visits covered under Medicare. Nor is the patient subject to any cost-sharing, e.g., deductibles or coinsurance, for covered home health services.

In addition to these SNF and home health care benefits, Medicare covers a range of long-term care services, and especically home care services, for terminally ill beneficiaries. These services, authorized in 1982 and referred to as Medicare's hospice benefit, are available to beneficiaries with a life expectancy of 6 months or less. Hospice care benefits include nursing care, therapy services, medical social services, home health aide services, physician services, counseling, and short-term inpatient care. For FY 1985, the Health Care Financing Administration estimates that Medicare expenditures for hospice care will amount to $15 million.

3. Social Services Block Grant Program--Title XX of the Social Security Act

Title XX of the Social Security Act authorizes a block grant to States for a wide range of social services to diverse population groups, including the aged, disabled, and children. States are allowed considerable discretion in their support of social services as long as the services are structured to meet the following goals of the program: achieving or maintaining economic self-support and self-sufficiency; preventing or remedying neglect, abuse, or exploitation; preventing or reducing inappropriate institutional care by providing for community-based care; and securing referral or admission for institutional care when other forms of care are not appropriate, or providing certain services to individuals in institutions (excluding room and board). The SSBG provides reimbursement for social services only, but will provide coverage for medical care when

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such care is "integral but subordinate" to the provision of a social service.

States receive allotments of SSBG funds on the basis of the State's population, within a Federal expenditure ceiling. There are no requirements for use of title XX funds--States are provided relative freedom to spend Federal social service block grant funds on State-identified service needs. Legislation in the 98th Congress permanently increased the expenditure ceiling to $2.7 billion, effective in FY 1984; in FY 1985 the appropriation level is $2.7 billion.

The title XX program was significantly changed by provisions of P.L. 97-35, the Omnibus Budget Reconciliation Act of 1981, effective in FY 1982. Through FY 1981, the program contained certain limited requirements regarding the population to be served and the kinds of services to be provided to families and individuals. Under provisions of P.L. 97-35, States have been given much more discretion in determining the service population and services to be offered. The law eliminated requirements that States expend a portion of funds for welfare recipients, that services be limited to families with incomes below 115 percent of the State median income, and that fees be charged to persons with specified income levels. While previous State planning requirements were lessened, the law continues to require States to develop and make public a report on how funds are to be used prior to the State plan period, including information on the types of activities to be funded and the characteristics of individuals to be served.

The 1981 law also eliminated State reporting requirements; therefore, only very limited data are available as to the extent to which title XX suports long-term care services. According to a DHHS analysis of the States' FY 1985 pre-expenditure reports under title XX (a report on States' intended use of funds), home care services, which may include homemaker, chore, and home management services, were to be provided by virtually all States (to adults and children); adult day care by 26 States; and adult foster care by 16 States.

According to data compiled by the American Public Welfare Association for a limited number of States, in 1983 home-based services were provided to 11 percent of total title XX recipients, or about 307,000 persons of all ages. Home-based services accounted for about 14 percent of total expenditures, or $555 million (out of a total estimated amount of Federal and State funds of $4 billion). 26/ It should be noted that these data are for total title

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26/ Data were compiled by the American Public Welfare Association under its Voluntary Cooperative Information System (VCIS) under which States voluntarily report data on their social service programs. Data for recipients are for 32 States and expenditures are for 31 States. Expenditures include State, local, title XX, and other funds. Data are published in A Statistical Summary of the VCIS Social Services Block Grant (SSBG): Data for FY83, October 1985.

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XX recipients; national data specific to the elderly and disabled population and by service are unavailable.

Although the SSBG represents the major social service program supported by the Federal Government, its ability to support significantly the long-term care population is relatively limited. Because it provides a variety of social services to a diverse population, the program has competing demands. Community care programs such as those supported by title XX are minimal when compared to programs which support institutional care. For example, Federal funds available for all title XX activities in 1983 ($2.7 billion) were approximately one-third the total Federal nursing home expenditures in that year ($8.1 billion).

4. The Older Americans Act

The Older Americans Act carries a broad mandate to improve the lives of older persons in the areas of income, emotional and physical well-being, housing, employment, social services, civic, cultural, and recreational opportunities.

The purpose of title III of the Act, which authorizes formula grants to States for services to older persons, is to foster the development of a comprehensive and coordinated service system for older persons in order to (a) secure and maintain maximum independence and dignity in a home environment for older persons capable of self-care; (b) remove individual and social barriers to economic and personal independence for older persons; and (c) provide a continuum of care for the vulnerable elderly. Under title III, grants are made to State agencies on aging, which in turn award funds to 664 area agencies on aging, to plan, coordinate, and advocate for, a comprehensive service system for older persons. Title III supports a wide range of supportive services, as well as congregate and home-delivered nutrition services. Certain supportive services have been given priority by Congress, including in-home services, such as homemaker and home health aide, visiting and telephone reassurance, and chore. Each area agency is required to spend a portion of its supportive services allotment on these services. Other community-based long-term care services which may be provided under title III include case management, assessment, adult day care, and respite care, among others. Services under the title III program are to be provided to older persons without regard to income, although concentrated on those with the greatest social or economic need. Older persons are to be given the opportunity to contribute to the cost of services, but failure to do so cannot be a basis for denial of service.

Unlike the title XX program in which States receive a block of funds for unspecified social services, Congress makes separate appropriations of title III funds for supportive services, for congregate nutrition services (in which older persons receive meals and other services in a group setting), and for home-delivered nutrition services. States receive allotments of these funds according to the

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number of older persons in the State as compared to all States. The law gives States and area agencies flexibility to define the supportive services to be provided and to transfer funds among the three service categories. Total FY 1985 appropriations for title III are $669 million, with 50 percent, or $336 million, for congregate nutrition services, and 40 percent, or $265 million for supportive services. Only about 10 percent of the Federal appropriation, or $68 million, is devoted to home-delivered nutrition services. 27/

In-home services clearly represent an expenditure priority for the title III program. According to the National Data Base on Aging, in 1984, about onequarter of funds controlled by area agencies (including Older Americans Act funds as well as non-Older Americans Act funds) was directed at in-home services. While a substantial portion of these funds was spent on the home-delivered meals component, which receives a separate appropriation under the Act, almost an equal proportion of the total spent on in-home services was devoted to housekeeping, personal care, and chore services. 28/

The ability of the Older Americans Act to have a significant impact on the long-term care system is limited due to its relatively small level of resources as compared to other programs. However, many State and area agencies have made strides to improve long-term care services through coordination activities with health and other social service agencies, and through the development of a social service infrastructure for the elderly at the local level. Some State agencies on aging have also acted as catalysts to reorganize community-based health and social services systems at the State and local levels so as to serve more effectively the long-term care population. For example, State agencies have developed case management and assessment systems through area agencies on aging and have supported services otherwise unavailable to the frail population. In other cases, State agencies on aging have been given responsibility for the administration of the section 2176 home and community-based waiver program under Medicaid. Although the amount of funding which title III devotes to home care services may represent a small fraction of the amount spent for home health services under Medicare and Medicaid, the title III program has the flexibility to fill gaps in services for persons otherwise unserved. Since Older Americans Act services may be provided without the restrictions required under Medicare and without certain income tests specified for by Medicaid, in some cases title III funds may be used to serve persons whose

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27/ Title III funding also includes appropriations for U.S. Department of Agriculture commodities or cash-in-lieu of commodities; $120.8 million is available in FY 1985.

28/ Data are from a random sample survey of 121 area agencies on aging in 1984. Supplied by the National Data Base on Aging, a service of the National Association of State Units on Aging and the National Association of Area Agencies on Aging.

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Medicare and Medicaid benefits have been exhausted or who are ineligible for Medicaid.

Although the home-delivered nutrition program receives less Federal funding than the congregate nutrition program, in recent years States have increasingly shifted funds from the congregate program to the home-delivered and supportive services components. In FY 1984 States shifted over $41 million from the congregate nutrition appropriated amount of $321 million to the other service components. Reasons cited for this trend include the increasing age of the older population and increased demand for home-based services by a more frail and older population. A recent evaluation of the Older Americans Act nutrition program performed for the Administration on Aging has shown that recipients of home-delivered nutrition services tend to be older, poorer, and in worse health than congregate nutrition participants.

Another long-term care activity required under title III is the operation of a statewide long-term care ombudsman program. This authority requires State agencies to conduct the following activities: investigate and resolve complaints relating to the health, safety, welfare, and rights of institutionalized persons; monitor Federal, State and local laws, regulations, and policies with respect to long-term care facilities; provide information to public agencies regarding problems of older persons in long-term care facilities; and establish procedures for access to facilities' and patients' records, including protection of the confidentiality of such records. Ombudsman activities are to take place not only with respect to policies and practices of nursing homes but also activities in boarding homes. State agencies responsible for the ombudsman program have created sub-State programs to carry out these activities; in 1984 there were about 400 sub-State ombudsman programs. In FY 1983, about $12.1 million was expended for ombudsman activities under the Older Americans Act ($8.9 million in Federal funds and $3.2 million from State and local funds). 29/

5. Supplemental Security Income Program--Title XVI of the Social Security Act

The Supplemental Security Income (SSI) is a federally administered income assistance program authorized by title XVI of the Social Security Act. Enacted by the 1972 Social Security Amendments and implemented in 1974, it replaced previous programs of State income assistance for the aged, blind and disabled. The SSI program provides a minimum income level for aged, blind, and disabled persons whose countable income does not exceed the Federal maximum monthly SSI benefit. In 1985 the monthly Federal SSI benefit is $325 for an

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29/ Data are from Administration on Aging testimony at a hearing before the House Select Committee on Aging, Sept. 10, 1985. Unpublished hearing record.

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individual and $488 for a couple with no other income. SSI payments are made to individuals under uniform, nationwide rules with respect to income and assets, and definitions of blindness and disability. In 1985 an estimated 4 million individuals will receive Federal SSI payments (1.5 million aged persons and 2.5 million blind or disabled persons). 30/

The SSI program also allows States to supplement the Federal SSI payment through optional supplemental payments to individuals. All but eight States and jurisdictions provide some form of optional State payments. (These are Arkansas, Georgia, Kansas, Mississippi, the Northern Mariana Islands, Tennessee, Texas, and West Virginia.) Each State determines whether it will make a supplemental payment, to whom, and in what amount. These State supplemental payments, also paid on a regular monthly basis, are intended to supplement the basic Federal SSI payment for food, shelter, clothing, utilities, and other necessities. Some States provide optional State supplemental payments to all persons qualifying for SSI benefits, while others may limit payments to certain State-defined SSI recipients, or may extend payments to persons who would be eligible for SSI except for excess income.

Because the Federal SSI payment may be insufficient to cover an individual's service needs which extend beyond room and board, such as non-medical supervision or other group living arrangements or personal care services, a significant number of States provide supplemental payments to support selected community-based long-term care services. These services often include supervision of daily living or other protective housing services for the mentally retarded, chronically mentally ill, or the frail or confused elderly.

An analysis of optional State supplemental programs as of January 1985 shows that 35 States support a diverse range of community-based long term care services through their optional State supplementation programs. 31/ Payments are made to individuals to support their residence in a variety of housing arrangements such as adult foster care homes, domiciliary care homes, congregate care facilities, adult residential care homes, and shared homes for adults. In addition to providing payments for specialized housing arrangements, some States also provide supplemental payments to pay for personal care, home health and other home care services for eligible individuals.

30/ This number includes persons receiving Federal SSI payments and/or Federally administered State supplementation.

31/ Information was compiled by CRS from The Supplemental Security Income Program for the Aged, Blind, and Disabled, Characteristics of State Assistance Programs for SSI Recipients, Social Security Administration, SSA Pub. No. 17-002. Jan. 1985.

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B. Federal Research and Demonstration Initiatives

Over the last decade the Federal Government has supported a wide range of research and demonstration activities designed to test new ways of providing and coordinating long-term care services as well as to achieve costs savings in the provision of care. Federally funded demonstrations have been sponsored principally by the Department of Health and Human Services (DHHS), and within DHHS, by the Health Care Financing Administration (HCFA) and the Administration on Aging (AOA). In some cases, HCFA has waived Medicare or Medicaid service or eligibility requirements so that a fuller range of services may be provided to persons who would not ordinarily benefit under the existing programs.

Research and demonstration projects have ranged from those in which system-wide changes have been made in the provision of community services to those in which the existing service system has been modified by the addition of previously unavailable services. The organization, administration, auspices, funding source, and service packages have differed across demonstration projects; however, certain common features exist. Many projects were geared toward the development of procedures to provide assessment, case management, and follow-up of clients with long-term care needs in order to assure care in the least restrictive setting. Multidisciplinary teams (generally composed of medical, health, and social service professionals) were established to accomplish this objective. Most projects aimed to provide or access a range of health and health-related social services for specified client groups, including homemaker, home health, chore, home-delivered meals, adult day health, and transportation.

Most of these projects have terminated as Federal demonstrations, but most have been viewed as precursors to the DHHS National Long-Term Care Channeling Demonstration Program funded for the first time during FY 1980. Another more recent research and demonstration initiative is the Social/Health Maintenance Organizations (S/HMO) project.

1. National Long Term Care Channeling Demonstration

In 1980, three units within the Department of Health and Human Services, the Health Care Financing Administration, the Administration on Aging, and the Office of the Assistant Secretary for Planning and Evaluation, initiated the National Long-Term Channeling Demonstration. This project was designed to test whether a carefully managed approach to the provision of community-based long-term care services to a frail elderly population living outside institutions could help control overall long-term care costs while maintaining or improving the well-being of its clients.

The term "channeling" refers to organizational structures and systems which coordinate available long-term care resources and manage them effectively on behalf of clients. Channeling was

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expected to achieve its effects principally by substituting less costly community or informal services for more expensive institutional care. Ten States received multi-year demonstration funds, and, as of March 1985, all States had terminated the demonstration phase. The program, designed with treatment and control groups, was devised to answer questions which previous demonstrations had not totally answered, such as the cost of case management systems and how best to target community-based services on those who would otherwise be institutionalized. Other questions to be answered by the demonstration included: Does channeling reduce institutionalization and hospitalization? Is use of formal health and social services in the community increased? Do formal services substitute for services of families and friends? What impact does channeling have on public and private costs of long-term care, on longevity, improved health status, and overall client well-being?

Final results of the demonstration will not be available until March 1986. However, results of a preliminary analysis of 3,000 early enrollees in the program indicate that the demonstration identified a very frail population with limited income living in the community. Of this early sample, 52 percent were incontinent, 22 percent were unable to perform activities of daily living, and 81 percent were restricted in mobility. A large majority needed assistance in preparing meals, shopping, and other housekeeping activities. In addition, 57 percent of the sample had income below $500/month.

2. Social/Health Maintenance Organization Demonstration

In 1980, the Health Care Financing Administration, DHHS, and private foundations began funding the development, planning, and operation of the S/HMO concept for financing acute and long-term care services for an elderly population eligible for Medicare and/or Medicaid. The S/HMO concept builds upon and extends the health maintenance organization (HMO) model for financing acute, medical care services. Specifically, an HMO offers health insurance coverage for specific health care services on a pre-paid, capitation basis (the premium charge for enrollment) and either provides directly, or arranges to have provided, the health services covered under the insurance contract. The HMO is at risk for the costs of the services it covers; that is, it will experience some level of profit or loss on the basis of its ability to estimate in advance its revenues and the utilization and costs of services it provides.

The success of conventional HMOs in managing acute medical care services and costs suggested the possibility of expanding the concept to include long-term care services. Under the three-year HCFA S/HMO demonstration, four test sites across the country will assume responsibility for financing and providing a full range of medical and long-term care services under a fixed budget which is prospectively determined. The four S/HMO sites will serve an elderly population eligible for Medicare and/or Medicaid. These persons will range

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from the ambulatory well aged to the impaired elderly. Medicare, Medicaid, and private premiums will finance the services.

Long-term care services covered by S/HMOs will include nursing home services, home health services, homemaker/home health aide services, personal care, adult day care, respite care, and home-delivered meals. Each S/HMO site will have its own defined long-term care benefit. Because of limited experience with long-term care insurance and utilization, long-term care services will be covered up to a maximum dollar amount per year and will require a copayment. The limits range from $6,500 per year to $12,000. In addition, S/HMOs will gradually assume full risk for the utilization and costs of covered services.

The four demonstration sites began providing services in 1985 and will continue to do so through June 1988. An independent contractor will evaluate all four sites. In general, the S/HMO demonstration is intended to provide information about the cost effectiveness of providing services in an integrated and managed system of care, its impact on the utilization of health and long-term care services by the elderly, and its effect on the quality of care available to the eligible population. Among the specific questions DHHS expects this demonstration to address are the following:

- Whether comprehensive long-term care insurance can be marketed to a significant number of elderly;
- What combination of benefits, eligibility criteria, premium and marketing techniques produce a viable long-term care insurance plan;
- Whether a consolidated, pre-paid system of acute and long-term care services can produce greater system savings than HMOs serving Medicare beneficiaries with acute care services only;
- Whether the new privately financed long-term care benefits will significantly reduce nursing home admissions and Medicaid "spenddown";
- Whether quality of care, service continuity and access can be improved by consolidating acute and long-term care in a single managed system; and
- Whether informal support (i.e., care provided by family members, friends and community volunteers) of chronically impaired elders is enhanced in a pre-paid, risk-based, case-managed health care system offering both acute and long-term care services.

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C. State Level Initiatives

The fragmentation and lack of coordination among major Federal programs which support long-term care services have provided the States with major implementation challenges. The Medicaid, Social Services Block Grant, and Older Americans Act programs all delegate administration and implementation responsibility to the States, and, in so doing, require the States to deal with problems inherent in the different goals of these programs, as well as their varying eligibility requirements, service benefits, and reimbursement policies. These implementation problems have also resulted from the fact that fragmentation at the Federal level has been mirrored in State administration, with major long-term care programs being administered by different State agencies.

Many States have responded to these challenges by enacting legislation and/or creating initiatives to reorganize and restructure benefits offered through the Federal programs. Also, some States have consolidated the administration of various long-term care programs in a single State agency.

State initiatives to alter and coordinate their long-term care policies have been inspired, in part, by federally sponsored demonstration projects begun in the 1970s. For example, demonstrations funded under Medicaid and Medicare waiver authorities and the Older Americans Act research and demonstration authorities have served as models for State-mandated case management systems and nursing home preadmission screening programs. Demonstration initiatives have also served as a testing ground for new community-based service models. For example, adult day care demonstrations which took place during the 1970s encouraged State and local agencies to merge existing health and social service funds available under Medicaid, title XX, and the Older Americans Act to create the now more than 1000 adult day care programs in existence.

Certain parallel activities have been initiated by States without the benefit of Federal demonstration funds and without any changes in Federal legislation. A number of States have attempted to reduce the need for institutional care by redirecting existing Federal program funds or by using existing Federal and complementary State funds in new ways. For example, the Virginia State Medicaid agency operates a nursing home pre-admission screening program through local public health departments for persons likely to be admitted to a nursing home but whose needs could be addressed through community-based services. The Massachusetts State agency on aging has established community-based organizations to manage certain key home care services for older persons through creative use of title III Older Americans Act funds and State funds. The Utah State agency on aging has established a program to identify persons at risk of being institutionalized and has developed alternative community-based service plans using personnel of the State's area agencies on aging network.

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The objective of reducing institutional care costs and diverting potential users to other forms of care has been the impetus behind much of the State effort to alter long-term care systems. Despite unclear evidence about the costeffectiveness of substituting various forms of community-based care for institutional care, an enormous amount of State effort has been directed at developing community care options.

Some of the themes evidenced in State level initiatives include the following:

- Control of institutional access through screening/assessment procedures. Many States have initiated screening and comprehensive medical and social assessment procedures of those "at risk" of long-term care services in order to ascertain the most effective and least costly care option, given the client's needs. Such screening and assessment procedures are generally applied to persons about to enter a long-term care facility. A review of State Medicaid programs in 1981 showed that 28 States had mandatory preadmission screening programs for Medicaid patients prior to nursing home admission. 32/

- Reorganizing access to community services. Some States have devised projects aimed at reorganizing access to community services by providing case management services or "gateway" procedures for clients. This concept has been developed to overcome problems associated with multiple providers and duplication of services that have resulted in client confusion as to source of care and unnecessary administrative costs among agencies. The availability of Medicaid funds under the 2176 home and community-based service waiver program has recently spurred the development of many more case management systems but perhaps not on a statewide basis. Of the 95 2176 waiver programs approved as of April 30, 1985, 66 programs offered case management.

- Cost control mechanisms. Some States have eliminated the uncertainty of whether community care will exceed institutional care costs by pre-establishing upper cost limits on such care; for example, community care may be provided only when such care does not cost more than a certain percentage of institutional care. An example of this concept is contained in New York's Nursing Home Without Walls program. This cost control concept has been incorporated into the National Long-Term Care Channeling Demonstration program

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32/ Knowlton, Jackson, Steven Clauser, and James Fatula. Nursing Home Pre-Admission Screening: A Review of State Programs. Health Care Financing Review, v. 3, no. 3, March 1982. p. 78.

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and is a basic element of the Medicaid 2176 home and community-based service waiver program.

- Tax incentives for dependent care. Many States permit favorable tax treatment for families or other caretakers who care for dependent older persons. According to a survey of the National Association of State Units on Aging, 27 States and the District of Columbia have adopted some form of dependent care tax credits, generally designed to assist in the care of dependents by adults who are working or seeking work. Of these 27 States, five have enacted tax provisions specifically designed to assist caregivers with the expenses of caring for older persons. These States are Arizona, Idaho, Iowa, North Carolina, and Oregon. 33/

33/ National Association of State Units on Aging. State Tax Policy Options for the Elderly: A Guide for Aging Advocates. May 1985. Washington, D.C. p. 46-47.

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IV. PRIVATE SECTOR APPROACHES TO FINANCING AND DELIVERY OF LONG-TERM CARE

Budgetary constraints resulting from growing Federal deficits and increasing expenditures required under various entitlement programs which currently finance long-term care have served to shift the focus of the long-term care debate from reform of Federal programs to consideration of private sector initiatives which might relieve fiscal pressures on public programs and which at the same time may improve the elderly's ability to finance long-term care. Observers have also noted that the decline in the ratio of workers to retirees and the growth in numbers of the very oldest segment of the population may have a marked impact on the ability of public programs to support long-term care in the future. In addition, others point out that the economic status of future generations of the elderly may improve significantly and that they will therefore be able to pay for a larger portion of the cost of certain long-term care services.

The improvement in the economic status of certain groups of elderly may lead policy-makers to target public sector long-term care programs on the most needy income categories of elderly, while at the same time to encourage various private sector financing approaches which could assure greater protection against the cost of long-term care services for those who are relatively better off.

However, at the current time, most elderly do not have the resources to pay for the catastrophic expenditures associated with certain long-term care services over an extended period of time. For many, depletion of assets and income for the cost of care and subsequent Medicaid eligibility is the only remedy.

A number of private sector approaches have recently been suggested as potentially feasible alternatives for financing long-term care services. These range from ways to pool risks associated with long-term care need through private insurance and life care communities to conversion of an elderly homeowner's equity into a source of funds to pay for care. A discussion of these approaches and their feasibility for financing long-term care follows. It should be noted that these private sector alternatives may have only limited applicability for the large number of elderly who are poor or may be poor in the future. Another method of risk pooling, the social/health maintenance organization, was discussed above in the section on public financing and delivery. This report does not discuss still other options suggested as feasible alternatives for enhancing the elderly's ability to finance long-term care

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expenses, including the various tax code modifications proposed to encourage families to continue providing long-term care services.

A. Private Health Insurance Coverage for Long-Term Care

Among the private sector approaches receiving increased attention recently as a potential alternative for financing long-term care services is private health insurance. This alternative has been suggested not only because of growing fiscal constraints on public program expenditures, but more basically because private insurance coverage is currently available for a wide variety of health care services and catastrophic illness. Private insurance is generally not available, however, for long-term care services or the catastrophic costs associated with long-term care.

Expenditures for long-term services, and especially for nursing home care, not only strain the budgets of public programs; they are also a burden on private resources. In 1983, total national nursing home expenditures of $29 billion were financed about equally by public programs and private sources of payment. Public programs financed $14 billion of the total, and private sources $15 billion. Of total private spending for nursing home care in 1983, only two percent was paid by private insurance coverage. Ninety-seven percent of the total private spending for nursing home care was paid directly by the consumer out-of-pocket. The average annual cost of nursing home care exceeds $20,000 per year, representing a catastrophic expenditure beyond the financial reach of most elderly. 34/

In addition, private insurance coverage has been viewed as a feasible alternative because of general interest among the elderly population in purchasing private insurance to supplement their Medicare benefits. Nearly two-thirds of the elderly currently purchase such "medigap" policies. While these policies generally pay only certain deductible and coinsurance amounts for which Medicare beneficiaries are liable and do not cover long-term care, the widespread interest of the elderly in this broader coverage suggests to some observers that a market for long-term care coverage can and does exist.

Furthermore, evidence indicates that the elderly will have higher incomes and assets in the future which will enable them to afford premiums for coverage. One study has estimated that given future income levels and growth of pensions, approximately 93 percent of all married couples at age 65 and almost 60 percent of all single persons at that age would be able to purchase long-term care

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34/ Doty, Liu, and Wiener, p. 74.

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insurance with less than five percent of their cash income by the year 2005. 35/

Currently, relatively few insurance companies (studies indicate 16 to 25) write long-term care insurance policies which are substantially more comprehensive than standard medigap policies and which go beyond restrictive Medicare definitions for skilled nursing care to include intermediate and custodial care. It is estimated that about 50,000 elderly persons are presently insured under such plans. 36/ Premiums for most of the available policies increase with age of initial purchase. The plans vary by length of time benefits are covered, waiting periods before benefits can begin, and the conditions upon which benefits will be paid. Most plans provide indemnity benefits, paying a fixed amount for each day of covered service, thereby limiting the insurers' liability. In addition, most have utilization controls to further limit an insurer's liability and to protect the insurer against unnecessary utilization of benefits. These include medical screens and physical examinations for utilization of benefits, preexisting condition restrictions, prior hospitalization requirements, exclusion of mental and nervous disorders, and renewability limitations. Home care benefits, especially those related to custodial or personal care, are included in even fewer long-term care insurance policies. Often plans that cover any home care at all require a prior stay in a skilled nursing facility in order to reduce the large potential demand for home care among the majority of the covered population that has never been institutionalized. 37/

A number of barriers have been cited as impediments to the development of meaningful long-term care insurance policies. 38/ Traditionally, insurers have been concerned about the potential for adverse selection in long-term care insurance, where only persons more likely to need care actually buy insurance. In addition, insurers point to the problem of the induced demand for services that

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35/ Private Financing of Long-Term Care: Current Methods and Resources. ICF, Inc., Final Report Submitted to the Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, Phase I, Jan. 1984. p. 79.

36/ Private Financing of Long-Term Care, p. 12. For a review of plans, see also, Meiners, Mark. The State of the Art in Long-Term Care Insurance. Long-Term Care Financing and Delivery Systems: Exploring Some Alternatives. Conference Proceedings. Health Care Financing Administration, Department of Health and Human Services, Jan. 24, 1985.

37/ Increasing Private Financing of Long-Term Care: Opportunities for Collaborative Action. SRI International, Aug. 1985. p. 14.

38/ Long-Term Care: The Challenge to Society. Health Insurance Association of America, 1984.

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can be expected to be generated by the availability of new long-term care insurance. With induced demand, individuals decide to use more services because they have insurance and/or will shift from non-paid to paid providers for their care. This is especially critical in long-term care with 60 to 80 percent of disabled or impaired persons receiving home care services from family or friends who are not compensated.

Still other factors are mentioned as problems inhibiting the development of long-term care policies. Many long-term care services that are felt to be critical in enabling frail elderly persons to remain in their homes are custodial, non-medical services. Traditionally these services, such as personal care, homemaker, and nutritional services are considered noninsurable because of difficulty in confining eligibility to a limited number of people. In addition, observers have noted that, given the nature of many chronic conditions, many people who need long-term care will need it for the remainder of their lives, resulting in an open-ended liability for the insurance company. Moreover, evidence exists that the elderly do not understand their insurance coverage or their potential need for long-term care. Some elderly believe they are already adequately covered for such services under Medicare while others think they have coverage for long-term care with their purchase of a medigap policy. 39/ Therefore, they do not demand specific coverage for long-term care.

According to a study of the Health Insurance Association of America (HIAA), one of the most significant barriers to the development of private insurance options is the major role played by Medicaid in financing long-term care and especially nursing home services. According to the HIAA report, Long-Term Care: The Challenge to Society, Medicaid is already viewed by many as a national coverage program for long-term nursing home care, used by far more than the low income population usually thought of as Medicaid's primary clients. In addition, the ability of individuals to plan for the transfer of assets expands the number of persons eligible for long-term care benefits under the program. According to HIAA's report, public programs are viewed as a safety net providing protection against the catastrophic costs of care. The report calls for reduced Medicaid involvement in financing nursing home care so that fewer middle income individuals can view the program as a viable option for their long-term care needs.

As noted above, the number of long-term care insurance policies providing meaningful protection for the at-risk elderly population is very limited. However, recent research suggests that many of the barriers that are commonly thought to preclude the development of long-term care insurance are subject to resolution by careful policy specification, including limitations on number of days

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39/ Long-Term Care Research Study. American Association of Retired Persons, Jan. 30, 1984, p. 3.

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covered, waiting periods before benefits can begin, and maximum amounts payable. 40/ In addition, research has found that significant reductions in annual premium rates could be offered if persons were encouraged to buy at younger ages and to accept longer periods before coverage begins and shorter length of coverage for benefits. 41/ Others have suggested that allowing families to purchase protection for their elderly parents could make long-term care insurance a more feasible option. Adding adult children, who have a much lower risk of incurring long-term care expenses for themselves, to the pool of the insured could expand premium collections and at the same time make a policy more affordable. The adult children could pay for the premiums on behalf of their elderly relatives as well as themselves, but presumably they would not begin to make claims for long-term care services on their own behalf until some future time.

Non-traditional health insurance alternatives have also been advanced as viable options for long-term care financing. Some have suggested that long-term care services can be controlled only in a managed care system, such as an HMO. The social/HMO demonstration project described above will provide information about the feasibility of this approach. In addition, some have pointed to taxpreferred cash accumulation plans, such as individual retirement accounts (IRAs) reserved for long-term care costs, as possible approaches to be considered. Some have suggested that cash accumulation instruments are perhaps most appropriate when there is a very high probability that a person will need a service at some point in time and when the costs of the service are not beyond the means of a person's life-time savings capacity. 42/ Home care services might be a more likely candidate for this form of financing than a long nursing home stay.

It should be noted that while insurers remain reluctant to enter the market for long-term care insurance, States, faced with mounting Medicaid nursing home expenditures, are expressing increasing interest in having such coverage more widely available. According to the American Health Care Association, which represents nearly 8,000 nursing homes in the country and which is a leading advocate of private long-term care insurance, 24 States are currently involved in some activity related to options for enhancing private insurance for long-term care. 43/ Legislatures in a number of States have

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40/ Meiners, The Case for Long-Term Care Insurance.

41/ Meiners, Mark and Gordon Trapnell. Long-Term Care Insurance: Premium Estimates for Prototype Policies. Medical Care, v. 22, no. 10, Oct. 1984.

42/ Increasing Private Financing of Long-Term Care: Opportunities for Collaborative Action. SRI International, Aug. 1985. p. 10.

43/ Lewin, Marion Ein. Reported in preliminary research findings on private insurance for long-term care. American Enterprise Institute, forthcoming.

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introduced bills that would mandate long-term care insurance coverage for group policies sold in the State. In addition, the National Association of Insurance Commissioners currently has underway a study group to assist State insurance commissioners in evaluating the increasing number of requests by insurers to establish policies.

B. Life Care or Continuing Care Retirement Communities 44/

One long-term care living arrangement available for financing long-term care services for a limited but potentially growing number of elderly persons is the life care community. Life care, also called continuing care retirement communities, are organizations, usually situated on a campus-like setting, established to provide housing, meals, housekeeping, and social activities, to older persons for the duration of their lives. In addition to these basic services, life care communities provide a range of long term care services offered on the grounds of the facility.

A distinguishing characteristic about life care communities is the guarantee that residents will be provided with a range of services as long as they are residents of the community. Rights and obligations of the resident and the community are defined under the terms of a life care contract. The life care contract sets forth the services to be received by the resident in exchange for financial payments, including an entrance fee and monthly charges. Because the life care contract is intended to provide financial protection against the future cost of long-term care services for each resident, it may be viewed in part as a form of insurance.

Long-term care services provided in a life care community may include skilled and intermediate nursing home care, personal care, and other health care services such as home nursing, and physical, occupational, or speech therapy. Life care communities may differ in the amount of pre-paid nursing care offered under the terms of the contract. Acute care and hospital care are not provided, and some communities may require the resident to share in the cost of health/ long-term care services they receive from the community. Residents continue to use Medicare and/or private insurance plans to cover the costs of acute and long-term care services.

Generally residents who enter life care communities are relatively healthy but as their health/long-term care needs increase, they are provided with increased services as stipulated under the terms of the life care contract.

The number of life care communities is currently very small. Two major studies of communities have provided a range of estimates of the numbers of communities--from about 300 to 600, depending upon

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44/ Portions of this section were drawn from a forthcoming CRS report on life care communities by Evelyn Howard.

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the definition used. It is estimated that there are at least 90,000 persons residing in nearly 300 such facilities. 45/ According to the American Association of Retired Persons, the number of life care communities doubled in the past 10 years and is expected to more than double in this decade. 46/ Most of the life care facilities in existence are operated by private, non-profit organizations, especially religious organizations, although there has been increasing interest on the part of corporations in developing such facilities.

In order to gain access to a life care facility, a resident is required to pay a lump sum entrance fee with monthly payments thereafter which are usually adjusted for inflation. Fees are generally based on the size and type of living unit (e.g., studio, one-, two-, or three-bedroom apartment). In addition, fees are based on some actuarial assumptions, such as life expectancy rates and projected future health care needs.

Some analysts have observed that the entrance and monthly fees may make the life care community option inaccessible to large numbers of elderly. A 1984 study by Laventhol and Horwath of 600 communities found that the range of entrance fees was between $4,000 to over $100,000 depending upon a number of factors, such as location, size of living unit, and age of facility. 47/ Some analysts, however, dispute the claim that life care is only for the relatively well-off elderly. A study of communities by Winklevoss and Powell indicates that although the range of entrance fees is wide, the average fee is moderate. According to this survey, the average entrance fee for 275 communities in 1981 was about $35,000 for one person and $39,000 for two persons, with average monthly payments of $562 and $815, respectively. 48/

45/ These estimates are from the following sources. A 1984 study, Continuing Care Retirement Communities: An Empirical, Financial and Legal Analysis [by] Howard E. Winklevoss and Alwyn V. Powell estimated that there were about 275 life care communities serving about 90,000 elderly persons. Another survey of the life care industry in 1984 by Laventhol and Horwath, estimated about 600 communities.

46/ American Association of Retired Persons. National Continuing Care Directory, edited by Ann Trueblood Raper. Washington, D.C., 1984. p. 5.

47/ Laventhol and Horwath. Life Care Industry, 1984, Philadelphia, Pa., p. 7. This report makes a distinction between facilities which are "principally life care facilities" and those which are "oriented toward nursing care." The former refers to facilities where there are two or more apartments per nursing care bed, and the latter refers to facilities where there are fewer than two apartments per nursing care bed. The range of fees cited here include both types.

48/ Winklevoss and Powell, p. 12.

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Analysts have pointed out that the life care concept can be viewed as a form of long-term care insurance in that residents pool their resources and share the risk of future costs of long-term care services. A portion of the entrance fees and monthly fees paid by all residents is used by the community to pay for the health and long-term care costs of a small number of residents needing more extensive care at any given time. Because only a small number of residents would be expected to need intensive services at a given time, the fees could be considered like insurance premiums paid by the entire group but used by only a small group at a given time. In some cases, participation in a life care community may be viewed as a form of income redistribution when some portion of the fees paid by all residents are used to subsidize the costs of residents who can no longer afford to pay for their care. 49/

Supporters of life care communities indicate that there are a number of advantages in this mode of long-term care. Life care communities offer continuous, and in large part pre-paid health and supportive care in a protected setting with personal and financial protection against the costs of future health/long-term care needs. Residence in such a community may offer increased opportunities for residents to maintain their relatively healthy status upon entry since professional oversight is available on a regular basis, as compared to completely independent living in the community where older persons may not actively seek health promotion opportunities. Residence in a protective community which offers a range of care situations may allay the fears that many elderly face of making a sharp transition from their homes to permanent residence in a nursing home when they become suddenly disabled. The pooling of health and long-term care risks may reduce the uncertainties of future costs of care, and the care provided under the terms of the life care contract can supplement coverage of acute care provided by Medicare and private health insurance.

While life care communities may offer an option to some elderly, and even increasing numbers in the decades to come, they may not be able to serve a large proportion of the elderly population in general. Life care is not an option for the poor elderly or those with relatively intense pre-existing health/long-term care needs. The idea of signing over a large portion of accumulated assets in one lump sum to an organization in return for protection against future costs may not be acceptable to large numbers of elderly persons. Turning over assets in such a way may eliminate inheritances for children.

While some elderly may not be able to afford the relatively hefty entrance fees, analysts have pointed out that the equity older persons have in their homes may be employed for this purpose. The proportion of elderly persons owning their homes is large and they have substantial equity as a result. Of the 17.7 million households

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49/ Winklevoss and Powell, p. 13.

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headed by older persons in 1983, 75 percent were owners. In 1980, about 84 percent of older home owners owned their homes free and clear, and in 1981 the median value of homes owned by the elderly was $44,000. 50/ One study points out that the high level of net home equity held by the elderly is not held only by those with higher income. About 65 percent of all elderly poor are homeowners, with 22 percent of the poor having more than $50,000 in net home equity. 51/ Other analysts indicate that because future generations of elderly will be better off than those of the past, the elderly may be in more advantaged positions to afford this kind of care in the future. Inflation adjusted retirement income under Social Security combined with private pensions and with IRA income may make the inflation adjusted monthly fees associated with life care communities payable by increased numbers of future generations of elderly.

Experience with life care communities is limited as are data about their effect on costs of organizing an integrated, pre-paid approach to long-term care service delivery. While it has offered an attractive option to a small number of elderly persons in the past, there have been problems. Some communities have experienced financial problems due in part to poor actuarial assumptions about the projected longevity of residents and their future health care needs, resulting in depletion of funds to cover costs. In view of these considerations, there has been interest on the part of Federal and State officials in more oversight and regulation over the development of these facilities in the interest of consumer protection. 52/

C. Home Equity Conversion

The search for alternative approaches to long-term care services has led some researchers to analyze the feasibility of using the single largest asset most older persons have--the equity in their home. As pointed out in the previous section, about 75 percent of elderly headed households are owner occupied, and in 1980 about 84

50/ American Association of Retired Persons and the Administration on Aging. A Profile of Older Americans: 1984. p. 11.

51/ Jacobs, Bruce and William Weissert. Home Equity Financing of LongTerm Care for the Elderly. Long Term Care Financing and Delivery Systems: Exploring Some Alternatives. Conference Proceedings. Health Care Financing Administration, Department of Health and Human Services. Washington, D.C. Jan. 1984. p. 83.

52/ In 1978, the Federal Trade Commission began investigating management and marketing practices of some life care communities. See U.S. Senate Special Community on Aging, Life Care Communities: Promises and Problems. S. Hrg. 98-276, Washington, D.C. May 25, 1983. As of August 1985, 13 States have enacted statutes to regulate life care communities.

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percent of owners had no mortgage debt. The overall homeownership equity held by elderly is substantial. It is estimated that the total equity held by elderly homeowners with no mortgage debt is about $548 billion. This figure may underestimate the total equity available to the elderly since elderly homeowners with some remaining mortgage debt are not included. 53/ Some observers believe that, if converted into a source of cash, homeowner equity could be a tangible means of financing long-term care services for some elderly who are "house rich, but cash poor."

There are two major types of mortgage instruments which may be used to convert equity into income: reverse mortgages, and sale/leaseback contracts. 54/

- Under the reverse mortgage, the homeowner enters into a loan agreement with a financial institution which uses the property as security for the loan. The older person retains ownership rights to the home, receives a regular stream of income based on the loan, and accumulates a debt on the loan amount. The loan may be calculated so as not to exceed some proportion of the property value. When the loan becomes due the owner has the option to convert the debt into a regular first or second mortgage, to sell the property to pay off the debt, or obtain a new reverse mortgage. The time period for the reverse mortgage may range from 7-10 years or for the remainder of the individual's lifetime depending upon the terms of the contract.

- Under the sale/leaseback contract, the homeowner sells the equity in the home but retains the right to reside there, usually for life. The buyer of the equity provides the elderly homeowner with a down payment and pays the balance in regular monthly installments. The seller, then, in effect becomes a renter of the home which he/she formally owned.

In one extensive analysis of the potential for application of homeowner equity toward payment of long-term care expenses, researchers concluded that there is evidence that a large proportion of

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53/ U.S. Congress. Senate. Special Committee on Aging. House Select Committee on Aging. Home Equity Conversion. Issues and Options for the Elderly Homeowner. Testimony of Kenneth Beirne, General Deputy Assistant Secretary for Policy Development and Research, Department of Housing and Urban Development. Briefing Document. House Pub. 99-513. Jan. 28, 1985. Washington, D.C. p. 58.

54/ Reverse mortgages are also sometimes described as "reverse annuity mortgages" or "loan plans." For further information, see Converting Home Equity Into Income for the Elderly: Issues and Options, by B. Ellington Foote, CRS Report No. 84-42. Apr. 5, 1984.

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older persons could use some of their home equity to finance long-term care needs. This analysis showed that about one-third to one-half of all elderly homeowners at high risk of need for home care could finance a portion of home care needs out of homeowner equity. The analysis also found that homeowner equity could be used to pay for long-term care insurance premiums as well as for nursing home care. 55/ Another analysis which reviewed the potential for use of term care needs. This analysis showed that about one-third to one-homeowner equity to purchase private long-term care insurance showed that home equity conversion could increase the ability of some elderly homeowners to pay for long-term care insurance, but concluded that reverse annuity mortgages and sale/leaseback arrangements do not easily provide for long-term care financing. Since these arrangements provide for payments to individuals for longer periods of time than usually needed to finance certain long-term care expenses, they may not have wide application for certain expenses requiring lump sums of cash over a short period of time. This report suggested that home equity conversion could be more useful if financial institutions permitted owners to use their homes as lines of credit, as necessary, to pay for long-term care expenses. 56/

While the idea of using home equity for payments of on-going expenses of the elderly has appeared in the literature for a number of years, the actual number of home equity conversion contracts is very limited (estimates range from 300 to 400 contracts at most). Lenders in only a handful of States have offered home equity loans and these loans may not be made on a regular basis. 57/ Therefore, the actual experience is relatively meager and its specific application to long-term care may be tentative.

55/ Jacobs, Bruce and William Weissert. Home Equity Financing of Long-Term Care for the Elderly. Long Term Care Financing and Delivery Systems: Exploring Some Alternatives, Conference Proceedings, Health Care Financing Administration, Department of Health and Human Services. Washington, D.C. Jan. 24, 1984. It should be noted that these findings were based on a model of probability of using home equity for this purpose, not on actual experience as to application of equity toward long-term care expenses.

56/ ICF Incorporated. Private Financing of Long-Term Care: Current Methods and Resources. Phase II. Submitted to the Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, Jan. 1985. pp. 25-26.

57/ According to an information paper of the U.S. Senate Special Committee on Aging, lenders in the following States have offered loans: Arizona, California, Maine, Minnesota, New Jersey, Ohio, Pennsylvania, and Wisconsin. See U.S. Congress. Senate. Special Committee on Aging. Turning Home Equity into Income for Older Homeowners: An Information Paper. S. Rept. 98-216. July 1984. p. 12.

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Thus far, there appears to be a lack of consumer demand. A number of obstacles have been cited as barriers to the future development of these arrangements. Many of the elderly may be reluctant to enter into these agreements because they wish to pass on some inheritance to their heirs. Also, even if this strategy were more widely available, some question whether the elderly would actually use the funds to pay for long-term care services. Other elderly may not participate because they may feel that services available from public sources will be decreased if they use their home equity. Also, they may feel that if they outlive their equity they may be forced to move. A number of other issues have been raised, including possible depreciation of homes, and concern that the elderly would not receive fair market value for their homes or that the lenders may default on the loans. These issues would require consumer protection measures.

There has been reluctance on the part of financial institutions to offer these instruments, particularly due to the current lack of mortgage insurance on the loans. Also, if the elderly homeowner lives beyond his/her equity, lending institutions may lose money because they may be reluctant to evict an elderly homeowner when the equity is exhausted. Finally, institutions may not want to enter into agreements in cases where the home is not expected to appreciate.

Other issues with respect to the tax implications of home equity conversions remain to be resolved. According to the Department of Housing and Urban Development (HUD), the status of sale/leaseback arrangements under the Internal Revenue Services (IRS) code is unclear. Questions in need of resolution include the right of the seller-lessee to take advantage of the one-time homeowner capital gains exclusion, and the ability of the purchaser-lessor to depreciate the rental property like other rental property. 58/

In 1983, Congress required HUD to develop a report evaluating the use of home equity conversion mortgages for the elderly, including the impact on financial institutions, the potential for acceptance of this concept in the private market, and any recommendations on the establishment of a Federal insurance program for insuring home equity mortgages. 59/

58/ U.S. Congress. Senate Special Committee on Aging and House Select Committee on Aging, Home Equity Conversion: Issues and Options for the Elderly Homeowner. Testimony of Kenneth Beirne, p. 59.

59/ This provision was included as part of P.L. 98-181, enacted Nov. 30, 1983. The report was due in Nov. 1984. As of Oct. 1985 the report is receiving HUD clearance.

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While home equity conversion is not extensively available, such arrangements may be attractive to some elderly for budgeted long-term care expenses if the market became sufficiently developed and loans were devised to be responsive to individual needs. Conversion of home equity into cash to be applied toward the down payment for life care facilities was discussed above. Conversion of home equity to remain in one's own home may be more attractive in the long run than using equity to finance a life care facility down payment. Because this option allows house rich, but cash poor elderly to remain in their own homes by drawing upon a ready flow of funds, it may ultimately appeal to many more persons than life care. It may particularly appeal to those without heirs who would benefit from the sale of the home upon the death of the homeowner. Advocates of this concept indicate that this strategy could generate a significant amount of funds which, if directed toward payment of long-term care services paid for by public sector programs, could reduce pressure on these programs.

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V. ISSUES TO BE CONSIDERED IN FUTURE PROSPECTS FOR LONG-TERM CARE

In the past, debate on Federal long-term care policy has focused on a number of issues which policy-makers still seek to resolve: how to offer more consistent and adequate protection for long-term care expenses; how to strike a balance between institutional and community-based care; and whether community-based care is more cost-effective than institutional care. Whereas in the past these issues were discussed principally in the context of proposals to reform Federal programs of support for long-term care, today questions arising from these issues are applied as well to a new dimension of the debate: the extent to which private sector alternatives, such as private insurance, life care communities, and home equity conversion, can improve the elderly's ability to finance the long-term care services they need and want. Although the debate may have widened to include private sector approaches, it is likely that reform of current Federal benefit programs will continue to be an area of consideration due to the large Federal investment in long-term care as well as the large numbers of elderly who depend upon these programs for assistance. Some of the questions to be reviewed in the future may include the following:

- What are appropriate roles for public programs and private sector options to play in the financing of long-term care? Can comprehensive long-term care coverage be provided without public mandate and/or subsidy? For example, the health insurance industry has been reluctant to offer comprehensive long-term care coverage, suggesting that adverse selection and induced demand for services will result in an insufficient pool of premium income to cover anticipated expenditures. What measures are necessary to obtain an adequate population base for long-term care insurance coverage that is affordable? Is some kind of public mandate required?

- Even if the economic status of future generations of the elderly improves significantly, it is likely that they will continue to have differentiated needs and abilities to pay for long-term care. How should public programs and private sector options respond to the needs of a diverse population? How can they most suitably complement each other?

- Can private sector alternatives begin to improve the ability of the elderly to finance their own long-term care expenses without reform of Federal programs of support? Currently many elderly persons have no other

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choice but to incur sizable out-of-pocket expenditures for long-term care, depleting their incomes and assets to become eligible for Medicaid's nursing home benefit. For these persons, Medicaid offers protection of the last resort. Others have pointed out that Medicaid is used by far more than a low-income population and that many middle income individuals are transferring their assets to relatives in order to qualify for Medicaid's nursing home benefit before actually incurring catastrophic long-term care expenditures. The Health Insurance Association of America has suggested reducing Medicaid's involvement in the financing of nursing home care so that fewer middle income individuals can use the program as a viable option for their long-term care needs. However, little is known about the number of persons who actually transfer assets in order to qualify for Medicaid's nursing home benefit. Out-of-pocket expenditures for nursing home care, on the other hand, amount to half of total national expenditures and are this high because private sector coverage is very limited and elderly persons must deplete their incomes and assets. Given these considerations, how should reform of public programs proceed?

- Public programs and limited private insurance currently provide more support for institutional forms of long-term care than for community-based care. Uncertainty about the costs of expanded community-based care has inhibited the broadening of coverage for these services. There appears to be consensus, however, that regardless of the cost of community-based services as compared to institutional care, community care is the more desirable option for most persons with chronic disabilities. Despite the prevalence of chronic conditions, most older persons are in reasonably good health and most chronically ill persons want to be as self-sufficient and independent as possible. There is also substantial evidence that family members would prefer to continue providing support services if some form of assistance were available to make their continued efforts possible. What kinds of controls must be in place for home care coverage to be more extensively included in public or private financing programs for long-term care? Can expanded home care coverage be included only in a managed care setting such as a social/health maintenance organization or life care community?

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